Vendetti Wellness Group, PC
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VENDETTI
WELLNESS GROUP PC

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

PATIENT INFORMATION

Patient Name:_____ Date of Birth: _____

Address:_____ Apt#:_____ City:_____ Zip:_____

Phone:_____ Email: _____

AUTHORIZATION

FROM (Physician/Office providing the information):	**TO (Person/Organization receiving the information):**
Send this completed form to this location listed below:	Please provide complete mailing address
Name:_____	Name:_____
Address: _____	Address: _____
_____	_____
Phone:_____ Fax: _	Phone:_____
_____	Fax/Email: _____

A PURPOSE

____Transfer of Care to New Provider
____Legal Matter
____Personal
____Insurance
____Other (specify)_____

B Information to be Released

_____ Clinical/Progress Notes Only
_____ Billing/Financial records
_____ Discharge Notes Only
_____ Entire Record/Chart
Note: selecting this option may result in a fee:
_____Other (specify):_____

CONFIDENTIAL PROTECTED INFORMATION

By signing below, I understand that this consent may include the disclosure of medical and mental health records that may include sexual trauma/abuse treatment, HIV/AIDS diagnosis & treatment, alcohol and/or drug abuse records, sexually transmitted disease records, prescribed medications, and lab test results.
I authorizethe release of all my medical records **except** _____ or N/A ☐

I ***understand*** I may withdraw my authorization at any time by submitting a written request to the office where I originally submitted this authorization. Authorization may be withdrawn except for the following: to the extent that action has been taken in reliance on this authorization or if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy. I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected. Information released on this authorization, if disclosed by the recipient, is no longer protected by ***Vendetti Wellness Group, PC***. *I understand that this authorization will automatically expire in 12 months, from the date of signature.*

Patient/Parent Signature:_____ Date: _____

**Legal documents must be attached if not signed by the patient.*

Signature of Legal Representative:_____ Date: _____

Print Name:_____Relationship of Representative to Patient: _____